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**ON BEHALF OF**  
**AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO**  
**AND THE AFGE NATIONAL VA COUNCIL**  
**BEFORE THE**  
**SENATE COMMITTEE ON VETERANS' AFFAIRS,**  
**CONCERNING**  
**THE**  
**FISCAL YEAR 2012 BUDGET**

**MARCH 2, 2011**

Chairman Murray, Ranking Member Burr and Members of the Committee:

The American Federation of Government Employees (AFGE) and the AFGE National VA Council (NVAC) (hereinafter "AFGE") appreciate the opportunity to testify today on the Fiscal Year (FY) 2012 budget for the Department of Veterans' Affairs (VA). AFGE represents more than 200,000 VA employees, including nearly 120,000 Veterans Health Administration (VHA) employees providing direct medical services to veterans.

AFGE's testimony focuses primarily on the portion of the VA's FY 2012 budget request that relates to "Clinical Staff and Resource Realignment". The budget request assumes yearly savings of \$151 million (in FY 2012 and FY 2013) based on three realignments:

- Conversion of selected physician to non-physician providers;
- Conversion of selected registered nurses (RN) to licensed practical nurses (LPN); and
- More appropriate alignment of required clinical skills with patient needs.

The lack of details in this proposal leaves many questions unanswered: Which physician duties will be assigned to an RN? Will LPNs replace RNs in both inpatient and outpatient settings? Will staff be realigned in behavioral health and specialized medical services?

Without more specifics, it is difficult to assess whether these proposed conversions to lower skilled positions will result in a more efficient use of scarce VA medical dollars,

or a harmful deskilling of the care we provide to veterans, many of whom are chronically ill or severely disabled. We urge the Committee to consider the following:

- How will the proposed staff realignment impact the quality of care that our veterans receive?
- How will it impact veterans' access to care?
- Will this realignment actually produce anticipated savings for taxpayers over the short run or the long run?
- Perhaps most important: Is the pursuit of these modest savings worth the risk of unintended consequences to veterans?

Fortunately, AFGE's assessment need not be purely theoretical; the VA is already attempting to achieve efficiencies through staff realignment, telehealth, team-based care, group appointments and shorter appointments, among other cost containment strategies. Unfortunately, what AFGE has learned so far from our gives us cause for concern. Too often, these realignments and cost containment strategies are implemented without proper oversight or advance planning, resulting in reduced access and quality of care. Also, rather than saving money, they sometimes cost the taxpayer *more*, in the form of costly contract care, less continuity of care and higher staff turnover. We also note that every time patients are reassigned, care coordination may suffer, clinicians have to spend additional time to learn the needs of a new patient, and veterans have to build relationships with new providers.

The impact of staff and resource realignment also will depend in part on whether it was planned or merely the unintended byproduct of budget shortfalls and hiring freezes. Yes, shortfalls and hiring freezes have not disappeared from the VHA

landscape despite advance appropriations for FY 2011. AFGE recently received reports of shortfalls and hiring freezes from several VISNs. At the Wilmington VA, the Director just announced that no one can be hired on a permanent basis and the medical center budget is frozen.

This news is both puzzling and troubling. AFGE joins the Independent Budget veterans service organizations (IBVSOs) in urging Congress, the Administration and GAO to ensure that this critical funding reform law is fully and properly implemented.

Staff and resource realignment can and should be used in certain instances. For example, in some facilities, RN tasks such as administration of flu vaccines and B12 injections, are being reassigned to LPNs. In addition, many VA clinicians are unnecessarily burdened by administrative duties, due to new initiatives and reporting requirements. These clinicians already have extremely limited face time with patients; many primary care providers cannot spend a lot more than 30 minutes with new patients, and rumors of 15 minute new patient appointments have resurfaced. Therefore, AFGE urges the Committee to take a close look at the growing administrative burdens placed on VA clinicians that divert scarce appointment time away from patient interaction. We also hope the VA will reconsider its current efforts to downgrade the Patient Support Assistant positions that provide critical backup to clinicians.

Clearly, the impact of staff realignments will also vary greatly depending on which medical services are targeted. At the Wilmington VA, the Pain Clinic Nurse Practitioner (NP) has had to run the clinic without the backup of an anesthesiologist. Like so many

other VA initiatives, inadequate funding is provided for proper implementation of the VA's National Pain Initiative. As a result, the Wilmington has to send veterans out to non-VA facilities for their pain injections, resulting in delays and fractionated care. If RN positions such as these were converted to LPNs, the adverse impact on care could be significant.

A report from a VISN 1 facility reveals similar realignment problems: That facility's Pain Team has a physician who mostly does back injections and an NP is in charge of medication management. For the more difficult and complex pain patients, it may be better and safer to have a physician perform medication management, especially when narcotics are involved.

Realigning that increases the portion of specialty care delivered by a non-physician can also lead to delayed and fractionated care. When orthopedic patients see an NP or physician assistant for their first visit, they often have to return for a second appointment or go elsewhere in order to be examined by an orthopedist.

At the Wilmington VA, realignment has adversely impacted veterans seeking emergency care for behavioral health problems. At the Wilmington VA, the first on-call for emergency behavioral health patients is a licensed clinical social worker. In this type of setting, physician extenders are placed under enormous pressures to carry out the duties and schedules designed for a physician, resulting in further burnout and higher attrition. They may also be forced to perform duties outside their scope of practice. More generally, AFGE urges the Committee to look at the attrition rate among social

workers and psychologists who are expected to carry out many of the duties of a psychiatrist.

Realignment-related problems may be especially difficult to detect and monitor in certain settings. For example, the Patient Aligned Care Team (PACT) is a laudable initiative that was recently described by Secretary Shinseki as an “historic step in redefining medical care”. Unfortunately, implementation of PACT has been hindered by short staffing and poor coordination. Physicians and nurses already handling enormous workloads are required to take on new PACT duties. In some facilities, the only way to staff a PACT team is to transfer clinicians away from departments that are severely short-staffed.

Our members report that some PACT teams operate without the regular participation of a physician. Then, the remaining team members are forced to “realign” themselves to cover the gap. AFGE has received several reports of RNs having to work outside their scope of practice as a result of these hard-to-detect realignment problems.

We also share the concern of the IBVSOs that PACT could adversely impact specialty care if not implemented properly; staffing and coordination problems are likely to worsen the impact.

Again, AFGE believes that PACT has great potential to improve VA care. We urge this Committee to investigate implementation problems and ensure that front line practitioners and their representatives have the opportunity to provide regular input into the evaluation process.

We also urge greater oversight of VA's Telehealth program. Here too, staffing problems that may be difficult to detect are hindering implementation of a valuable VA initiative. We are troubled by reports from several facilities that physicians are pressured to refer and keep veterans in telehealth programs, even when, in their professional judgment, another form of care would better serve the patient. (Some physicians have been offered cash incentives to divert patients to telehealth.)

In VISN 4, rural health care dollars were used to hire an NP at the Philadelphia VAMC. Then the VISN notified Wilmington's CBOC primary care providers that consults for cardiology, endocrinology and hematology/oncology could be placed through the coordinator at Philadelphia. If, after reviewing the consult, the specialist wants to see the patient, the patient would be required to bypass the Wilmington VA to go to the Philadelphia VA, even though Wilmington has the very cardiology, endocrinology and hematology/oncology specialty services the patient needs. (It is also troubling that the Philadelphia VA can only run an orthopedic surgery clinic one-half morning every other week, even though back and neck pain are among the top complaints causing veterans to seek care.)

Diagnostics is another area where conversion to lower skilled positions could be problematic. For example, depending on the medical need, an NP substituting for an internist may be required to work outside of his or her scope of practice.

As mentioned above, emergency care has suffered tremendously because of inadequate staffing. The goal is no longer to provide care to the veteran in the emergency department, but to refer the patient outside the VA system for care. At

Wilmington, VA, we recently learned that the emergency department is slated to increase its maximum capacity from six to fourteen patients, yet administration wants to provide *zero* increase in nursing or physician staff. Recently, five patients each spent over 48 hours in the emergency department, including one who received two blood transfusions while he lay on a stretcher for two days. Meanwhile a 25-bed ward has sat idle for the past three years because of too few floor nurses.

*Other concerns:*

AFGE is disappointed to see the return of VA's proposal to eliminate all continuing medical education (CME) reimbursement for physicians and dentists. The VA recruits prospective clinicians with the promise of professional growth, but is reluctant to comply with the 1991 law that entitles clinicians to a modest sum for courses required to maintain certification and professional licenses.

The justification provided (without any supporting data) in the FY 2012 budget request is that physicians and dentists no longer need this recruitment/retention benefit because the pay system enacted in 2004 has made the VA competitive with other employers. If VA is sufficiently competitive, why do so many facilities have trouble recruiting these clinicians, and why does the VA continue rely so heavily on more costly fee basis care to fill the gaps? Furthermore, the 2004 pay law (P.L. 108-445) made no linkage to lower CME costs, but it *did* link better pay with less fee basis care – a desired outcome the VA has still not documented.

Rather than arbitrarily cut this modest CME benefit, AFGE urges this Committee to first conduct comprehensive oversight of VA physician and dentist issues, including:

ongoing problems with the base, market and performance pay provisions in the 2004 law, its impact on VA's use of fee basis care, whether AFGE's CME program (again, still at 1991 levels) is competitive with other health care employers, the CME needs of other VA clinicians, and the impact of the physician/dentist "24/7" scheduling rule on recruitment and retention.

In addition, it would be valuable to finally understand why medical centers that run out of money to hire more front line practitioners usually find other funds to contract for more expensive non-VA care to fill the gap.

Perhaps, instead of looking for modest savings through realignment and the use of fewer physicians and RNs, the VA may want to examine the enormous growth of staff and resources at the VISNs, and the percentage of VISN staff that do not provide or support direct patient care.

Thank you.

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Dr. Maryann Hooker is a board-certified neurologist with the Department of Veterans Affairs Medical Center in Wilmington, Delaware. She is a graduate of The Medical College of Pennsylvania, now Drexel University College of Medicine, in Philadelphia, Pennsylvania, and completed both her internship in internal medicine and residency in neurology at Thomas Jefferson University Hospital in Philadelphia. During her internship and residency, Dr. Hooker rotated through the Wilmington VA Medical Center, and upon completion of her residency, she joined the Neurology Department staff, currently serving as Lead Neurologist for the facility. She teaches medical and surgical residents in training with Thomas Jefferson University Hospital. Dr. Hooker also trains residents in psychiatry for the Delaware Psychiatric Center and physical therapy doctoral students at the University of Delaware. She also serves as Secretary of AFGE Local 342.